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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on June 9, 2009 through June 12, 2009, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was 76 residents. The sample size was 16 sampled residents which included 3 closed records. There was 1 unsampled resident. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 167	Continued From page 1 failed to make the results of the most recent survey of the facility readily accessible for examination and ensure a posted notice of the same. Findings include: During the initial tour on 6/9/09 in the morning, revealed that there was no posted notice of recent survey results and the survey results were not available for examination. Following the initial tour of the facility, the Administrator (Employee #1), was interviewed. The Administrator indicated the survey results were kept on a shelf in a reception sitting area adjacent to the business office. Accompanied by the Administrator, the book shelves in the reception sitting area were reviewed. After looking over several shelves the Administrator located the binder with the survey results. The Administrator confirmed there was no notice indicating where the survey information could be found and that a notice should be posted so that examination of the survey results were readily accessible to the residents and visitors.	F 167		
F 222 SS=D	483.13(a) CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, document review, and interview, the facility failed to ensure the resident or their legal representative made an informed	F 222		

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F 222	Continued From page 2 choice about the risks and benefits of chemical restraints for 1 of 16 residents (#15). Findings include: A review of the facility's "Psychopharmacological Drug Usage" policy dated 9/08, identified psychotropic medications to include antipsychotics, antidepressants, antianxiety, and sedatives/hypnotics. The policy indicated, "Consent for the use of psychopharmacologic medications must be given in writing by the resident and/or the resident's representative. This consent form will also include educational components of: name of medication, condition/reason for its use, possible risks/side effects of the medication, and expected outcome/benefits of the medication." Resident #15 Resident #15 was admitted to the facility on 10/3/08 with diagnoses including dementia, senile with depression, osteoarthrosis, and paralysis agitans. Medication orders included the antimanic medication Lithium 300 mg capsule once daily, the antidepressant medication Wellbutrin 150 mg tablet twice a day, and the antidepressant Lexapro 20 mg tablet once daily. Resident #15's medical records lacked consents for Lithium, Wellbutrin, and Lexapro. The Director of Nursing, Employee #2, confirmed there were no consents for the medications.	F 222		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241		

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full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that residents received care which maintained or enhanced the individual's dignity and respect for 1 of 17 sampled residents (#17) and for 1 unsampled resident (#6).

Findings include:

On 6/12/09 at 7:15 AM, Resident #17 was observed wheeling herself slowly down the 300 hall to go to the dining room for breakfast. A Certified Nursing Assistant (CNA), Employee # 4, walked up behind the resident and said, "I'll push you down the hall." The resident's hands were still on the wheels when CNA quickly started pushing the wheelchair. The resident's head jerked back when the employee initiated the push, and the resident appeared to be startled. The CNA did not ask the resident if she wanted to be pushed quickly down the hall.

Resident #6

Resident #6 was a 51 year old female admitted to the facility on 3/7/07 with diagnoses including Huntington's Chorea and senile dementia with depression.

On 6/10/09 in the afternoon, Resident #6 was observed in the 400 Hall sitting area, across from the Dining area. Resident #6 requested medication for pain from the medication nurse. Resident # 6 pulled up her shirt, exposing her

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F 241	Continued From page 4 breasts. There were several residents sitting in the Dining area who could see Resident #6. On 6/11/09, the Activities Director (AD) (Employee #11), stated that Resident #6 had exposed her breasts several times including outing events. The AD reported Resident #6 exhibited this behavior when her pants did not fit properly so the staff tried to ensure that Resident #6's clothing fitted properly. When asked whether Resident #6 could wear undergarments, the AD stated she did not know why Resident #6 did not wear a bra.	F 241		
F 249 SS=C	483.15(f)(2) ACTIVITY DIRECTOR QUALIFICATIONS The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that the activities program was directed by a qualified	F 249		

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F 249	Continued From page 5 professional. Findings include: On the intial tour and throughout the survey (6/9/09 - 6/12/09), the activities program and staff was observed. Observations revealed there were two staff members dedicated to the activities program, the Activities Director (Employee #11) and the Activities Assistant (Employee #12). On 6/12/09, in an interview with the Activities Director, she revealed she was not certified, licensed or registered as a therapeutic recreational specialist or activities professional. The Director further indicated, her background was not in activities and that she was not currently enrolled in any classes or certification programs for activities. On 6/12/09, review of the Activities Director's personnel records, confirmed the director was not licensed, certified or registered as a therapeutic recreational specialist or activities professional.	F 249		
F 271 SS=B	483.20(a) ADMISSION ORDERS At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure there were physician's orders by the physician at the time of admission for 4 of 16 residents (#8, #9, # 11, #12). Findings include:	F 271		

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F 271	Continued From page 6 Review of Residents #8, #9, #11 and #12's medical records, both hard copy chart and computerized records, failed to reveal evidence of admission orders by the listed physician upon admission. On 6/11/09, the Director of Nurses (DON) (Employee #2), indicated that when they admitted a resident from another facility, they received documentation from the sending facility on the resident's care, along with a list of medications and treatments. When the facility received this information, it was reviewed by the licensed nurse who drafted orders and faxed the orders along with other documentation to the acting physician for his review and signed approval. The DON further indicated once the physician faxed back the signed orders for the admission, the orders were incorporated into the resident's medical record by either putting hard copies in the record or were scanned into the resident's computerized record. The DON agreed, looking through Resident #8, #9, #11 and #12's records (hard copy and computerized) that she could not confirm that each of the residents had approved admission orders by the listed physician upon admission. The DON indicated that the facility did not have a formal policy and procedure for admission orders.	F 271		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		

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A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on record review, document review and interview, the facility failed to ensure that 1 of 16 residents were invited to attend the care plan meeting (#5).

Findings include:

Resident #5

Resident #5 was a 65 year old male admitted to the facility on 3/31/09 with diagnoses including cerebral vascular accident (CVA) with left sided weakness, diabetes, hypertension and coronary artery disease.

On 6/11/09 in the afternoon, Resident #5 and his wife stated they were unaware that care planning meetings took place and that they could attend. Resident #5's wife stated she had never been invited to any meetings and she would like to attend to discuss discharge plans.

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F 280	Continued From page 8 The facility policy titled Care Plan Policy and Procedure dated 1/03 revealed: Composition of Care Plan Team "...The resident and/or responsible party shall be invited to participate in the formulation of his/her plan of care..." Frequency of Care Plan Meetings 2. "The initial care plan meeting conducted by the Interdisciplinary Team shall be completed no later than 21 days after admission..." The facility lacked documented evidence in the resident's record an Interdisciplinary (IDT) team meeting was conducted. On 6/11/09 at 1:30 PM, the Minimum Data Set Coordinator stated she sent a letter to the resident and responsible party to notify them of the care planning meetings. She added she also verbally told the resident about the meeting. The MDS Coordinator did not recall when Resident #5's meeting was scheduled but indicated he was scheduled for an IDT soon and would be sure to include the resident and his wife.	F 280		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure physician orders were clarified according to professional nursing standards for 1 of 16 residents (#14).	F 281		

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Findings include:

Resident #14

Resident # 14 was admitted to the facility on 2/12/09 with diagnoses including fracture of the tibia/fibula, urinary retention, congestive heart failure and diabetes.

A physician's order dated 2/12/09 indicated the following:
-"Novulin R (insulin regular human) Solution; 100 unit/ml (milliliter); Injection Special Instructions: Inject 10 units subcutaneously 30 minutes before each meal. Add one unit for every 50 > 200. For example, 200-250 = add 1 unit, 251-300 add 2 units, 301-350 add 3 units, 401 - 450 add 5 units. >450 call PMD (Primary medical doctor)."

The physician's order as stated did not clearly indicate the correct dose of Insulin to be administered when the resident's Blood Sugar (BS) was over 200.

Based on the physician's order which stated add one unit for every 50 >200, the Insulin dosage could be calculated as:
-250 - 299 - add 1 unit;
-300 - 349 - add 2 units;
-350 - 399 - add 3 units;
-400 - 449 - add 4 units;
> 450 call PMD.

There was no documented evidence that the nurse contacted the physician to clarify the Insulin order.

There was no documented evidence on the

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F 281	Continued From page 10 Medication Administration Record (MAR) of the exact dosage (units) given when the resident's BS was > 200. The Fundamentals of Nursing Concepts, Process and Practice, written by Kozier, Erb and Olivieri, 4th Edition, revealed: -Legal responsibilities in Nursing Practice: "...It is the nurse's responsibility to seek clarification of ambiguous orders from the prescribing physician. Clarification from any other source is unacceptable and regarded as a departure from competent nursing practice."	F 281		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, document review and interview, the facility failed to ensure 2 of 16 residents received necessary care in accordance with physician's orders (#5, #14). Findings include: Resident #5 Resident #5 was a 65 year old male admitted to the facility on 3/31/09 with diagnoses including cerebral vascular accident (CVA) with left sided weakness, diabetes, hypertension and coronary	F 309		

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artery disease.

Physician's orders dated 4/9/09 indicated:

Accucheck monitoring 4 times a day with sliding scale Insulin Coverage:

Blood Sugar	# Units
0-100	0
101-150	2
151-200	3
201-250	4
251-300	7
301-399	10

notify MD (medical doctor) if greater than 400

The Medication Administration Record (MAR) dated 4/9/09 - 5/9/09 revealed there was no accucheck readings or Insulin administration on the following dates:

4/13/09 4:00 AM; 4/16/09 at 10:00 PM; 4/17/09 at 4:00 AM, 10:00 AM, 4:00 PM; 4/19/09 10:00 PM; 4/23/09 10:00 AM, 4:00 PM; 4/25/09, 4/26/09, 4/27/09, 4/28/09, 4/29/09 at 4:00 AM

The MAR dated 5/11/09 - 6/10/09 revealed there was no accucheck readings or Insulin administered on the following dates:

5/3/09, 5/4/09 at 4:00 AM, 5/6/09 4:00 PM

The MAR dated 5/11/09 - 6/10/09 revealed there was no accucheck readings or Insulin administered on the following dates:

5/16/09 10:00 PM, 5/26/09 at 4:00 PM

The facility policy titled Medication Administration

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F 309	Continued From page 12 dated 2/04 revealed: Procedure: "7. In the event that a medication cannot be given, the reason must be documented in the Nurses Medication Notes on the MAR, and the time frame circled on the MAR." The facility lacked documentation in the Nurses Medication Notes or the progress notes why the accuchecks were not done and the medication not administered. Resident #14 Resident # 14 was admitted to the facility on 2/12/09 with diagnoses including Fracture of the tibia/fibula, Urinary Retention, Congestive Heart Failure and Diabetes. Physician's order dated 2/12/09 indicated the following: -"Novolin R (insulin regular human) Solution; 100 unit/ml (milliliter); Injection Special Instructions: Inject 10 units subcutaneously 30 minutes before each meal. Add one unit for every 50 > 200. For example, 200-250 = add 1 unit, 251-300 add 2 units, 301-350 add 3 units, 401 - 450 add 5 units. >450 call PMD (Primary medical doctor)." The physician's order as stated did not clearly indicate the correct dose of Insulin to be administered when the resident's Blood Sugar was over 200. There was no documented evidence that the nurse contacted the physician to clarify the Insulin order.	F 309		

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F 309	Continued From page 13 There was no documented evidence on the Medication Administration Records (MAR) for February, March and April 2009, which indicated the exact dosage of Insulin, in units, that was administered at any time. On 6/11/09 in the morning, two medication nurses revealed they were unable to identify how much Insulin was administered based on Resident #14's MAR. On 6/11/09 in the morning, the Director of Nurses reviewed Resident #14's MAR and indicated that the documentation did not reveal the amount of Insulin administered. She added this was the Corporate form the facility used and it did not have an area to document the Insulin dosage.	F 309		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, document review, and interview, the facility failed to prevent the development of a pressure sore for 1 of 16 sampled residents (#1). Findings include:	F 314		

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F 314	Continued From page 14 Resident #1 Resident #1 was initially admitted to the facility on 3/1/07 and was readmitted on 7/18/07, with diagnoses including renal failure, coronary artery disease, chronic obstructive pulmonary disease, and dementia. The Minimum Data Set (MDS) dated 4/14/09 revealed the resident had moderate cognitive impairment. A review of Resident #1's record revealed that he developed a pressure sore on 1/6/09. At that time, a care plan was created, outlining the following problem: "The resident has a Stage II pressure sore noted to Lt (left) ischium and is at increased risk for further pressure ulcers R/T dx. (related to diagnosis) of renal failure, decreased mobility, incontinence, decreased nutrition, decreased sensory perception, and is noncompliant with dressing changes." The goal was documented as, "The resident will have no skin breakdown during this quarter," and the target date was 7/22/09. The following approaches for this goal were in part, as follows: 5) side rails up to assist with turning and repositioning; 6) assist resident with turning and repositioning; 7) pressure reducing device in bed and W/C (wheelchair); 8) provide incontinent care after each incontinence episode; 9) provide clean/dry bed linen ..." Resident #1's record indicated that another Stage II pressure sore had developed at the same location (left ischium) on 6/8/09. The nurse on duty, Employee # 5, recorded his progress notes at 12:05 PM into the facility's computer system. After describing the cleaning of the wound, the nurse wrote, "Resident tolerated well... Resident is incontinent of b/b (bowel and bladder) and is	F 314		

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often non-compliant with direct care from staff, including brief changing and bathing. Resident spends most of his day sitting in his wheelchair. Resident encouraged to reposition himself frequently while in his chair." The nurse also input a description of the resident's pressure sore into the "event" section of the computer system, in order to alert other staff of the occurrence.

A review of the facility's "Protocol for Pressure Ulcer Prevention and Treatment" policy dated 12/04 was reviewed, and it included the following procedures: "1) A skin risk assessment is completed on all residents upon admission weekly for the first four weeks after admission, and quarterly; 2) Pressure ulcer will be care planned; 3) Incontinent residents will be taken to the bathroom at least every two hours if able. If residents are incontinent, perineal care will be given and the resident will be dried; ... 5) Special devices will be used to relieve pressure." Record review revealed that these four procedures were not adequately implemented for Resident #1, as described below:

1) The last skin assessment for Resident #1 was completed on 1/13/09. The resident's care plan did not address skin assessments.

2) The resident's first pressure sore had been care planned on 1/6/09, and, according to the DON, the same care plan was still in place as a means to prevent the development of new pressure sores. As of 6/10/09, it had not been updated to address the new pressure sore which was discovered on 6/8/09.

3) Resident #1's MDS dated 4/14/09 revealed that he was incontinent. The resident's care plan

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F 314	Continued From page 16 included the following approach: "Provide incontinent care after each incontinence episode." This approach had not been updated since the care plan was created on 1/6/09. A review of the resident's "CNA (Certified Nursing Assistants) Daily Documentation" sheet for the month of May revealed that the resident had been provided incontinent care an average of two times per shift. Two CNAs interviewed indicated they would usually provide incontinent care four times per shift, but the resident was "uncooperative and didn't want to be changed." The care plan did not address ways to ensure that incontinent care was being carried out as planned. 4) Resident #1's care plan included the approach "Pressure reducing device in bed and wheelchair." On the morning of 6/10/09 it was observed that the resident was sitting in his wheelchair without a cushion. A CNA, Employee # 4, was asked about the cushion, and she indicated that it was sometimes missing, either because it was being laundered or the resident liked to take it off. The care plan did not address ways to ensure that the cushion would remain on the wheelchair.	F 314		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		

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F 315	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure appropriate medical justification for Foley catheter insertion for 1 of 16 residents (#5). Findings include: Resident #5 Resident #5 was a 65 year old male admitted to the facility on 3/31/09 with diagnoses including cerebral vascular accident (CVA) with left sided weakness, diabetes, hypertension and coronary artery disease. The Nursing Body Assessment Form completed on 3/31/09 revealed Resident #5 had a Foley Catheter. The Assessment form-Elimination - Indwelling Catheter Evaluation dated 4/9/09 indicated Resident # 5 had a diagnoses of Hemiplegia, non dominant side and a Stage II pressure ulcer to the Right Buttock as rationale for the catheter use. There was no documented evidence of a medical justification signed by the physician for the Foley catheter. On 6/14/09 in the morning, the Director of Nurses confirmed there was no medical justification for the Foley Catheter on Resident #5.	F 315		
F 325 SS=G	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a	F 325		

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resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:
Based on record review, document review, and interview, the facility failed to prevent a significant weight loss, conduct an accurate nutritional assessment, and monitor nutritional status for 1 of 16 sampled residents (#1).

Findings include:

Resident #1

Resident #1 was initially admitted to the facility on 3/1/07 and readmitted on 7/18/07 with diagnoses including renal failure, chronic obstructive pulmonary disease, coronary artery disease, and dementia. The Minimum Data Set (MDS) dated 4/14/09 revealed the resident had moderate cognitive impairment and was eating with supervision and set up help only.

Record review revealed that Resident #1's admission weight was 140 pounds (with a height of 72 inches), and his Body Mass Index (BMI) was 19 (at the lower end of the "normal weight" range of 18.5 to 24.9). The resident's therapeutic Renal diet care plan included the following goal (with a start date of 7/18/07): "Resident will

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maintain a healthy weight by next review." By 12/9/08, the resident's weight was 132 pounds, putting him into the underweight category, with a BMI of 17.9.

Resident #1's care conference meeting notes, dated from 5/8/08 to 4/23/09, were provided. The resident's weight loss and low BMI were not addressed in any of the quarterly care conferences and the care plan had not been updated to address the weight loss.

A review of the facility's "Liberalized Diets" policy included the following guideline: "If a resident begins to lose weight, their intake will be evaluated and the meal pattern will be adjusted to increase calories and nutritients. A variety of between-meal nourishments / supplements may be offered." There was no evidence that Resident #1's weight loss had been evaluated or that his diet order had been adjusted.

Two nutritional assessments for Resident #1 were provided by the facility.
- One of the assessments was conducted on 1/13/09 by the facility's former dietary manager. She recommended a 1600 calorie diet, with fluid needs of 2700 cubic centimeters (cc), and she noted the following: "Initial fact finding assessment completed, RD (Registered Dietitian) to review and make recommendations."
- The second nutritional assessment was conducted on 4/14/09 by the current dietary manager, Employee #6. The resident's weight was 128 pounds, and the dietary manager recorded a recommended intake of 2400 calories daily, with 2400 cc hydration. There was no evidence that the dietitian had reviewed either assessment or agreed with the calorie and fluid

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intake calculations recommended by the two dietary managers.

Record review on 6/9/09 revealed that Resident #1 experienced a 6.4% weight loss between 5/4/09 and 6/5/09 and the weights were recorded in pounds, as follows:

5/4/09 - 130
5/25/09 - 124
5/31/09 - 122
6/5/09 - 121

Resident #1's medication administration record (MAR) included an order for weekly weights; however, the Vitals Results sheet did not indicate that weights had been taken every week. The unit nurse, Employee #8, indicated that if weights had been taken, they would have been input on the Vitals Results form.

Resident #1's meal intake record for the month of May was reviewed and revealed while the resident's intake for breakfast was adequate, his intake for lunch and dinner ranged from 0 to 60%. Fluid intake averaged 1100 cc daily. The record indicated that snacks had not been consumed.

A review of the facility's "Weight Monitoring" policy dated 3/04, revealed the following procedures: "Excessive weight gains or losses, or weights that are outside the established IBW (Ideal Body Weight) must be brought to the attention of the Food Service Supervisor. RD to review weight loss/gains on monthly basis, and make recommendations to physicians as necessary."

An interview with the facility's dietary manager,

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F 325	Continued From page 21 Employee #6, was conducted on 6/10/09. Employee #6 indicated that she was unaware of Resident #1's current weight loss. The percentage of his weight loss did not trigger an alert in her computer program, which would have prompted Employee #6 to put the resident on her "weekly weights list." Employee #6 further reported that she printed this list every Thursday for the nursing staff to review. The Director of Nursing (DON), Employee #2, confirmed that the facility's procedure was for the dietary manager to provide nursing with the list, and the DON would notify the dietitian or the physician of the need for nutritional supplementation. The DON agreed that Resident #1 should have automatically been put on the "weekly weights list." An interview with the dietitian, Employee #7, was conducted by phone on 6/10/09 at 3:30 PM. Employee #7 indicated that she came to the facility "at least 2 to 3 times a month" and went to the facility on 6/8/09 at 3:00 PM, but was unaware of Resident #1's recent 6.4 % weight loss, inadequate fluid intake. She did not assess the resident's nutritional status. The dietitian revealed she was usually informed verbally by nursing staff of residents needing to be seen, but was not informed about Resident #1 on 6/8/09. On 6/10/09 at 11:00 AM, the DON acknowledged that Dietary had not been informed about providing the shake for the resident. The DON further stated, "A nurse should have notified the dietitian, the DON, and Dietary."	F 325		
F 329 SS=E	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		

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unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on record review, document review, and interview, the facility failed to ensure that gradual dose reductions were attempted for psychotropic medications used by 3 of 16 sampled residents (#2, #10, #15).

Findings include:

The facility's "Psychopharmacologic Drug Usage" policy dated 9/08 included the following procedures: "Gradual Dose Reductions (GDR) must be attempted. For Sedatives/Hypnotics, a

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reduction should be attempted at least quarterly, unless clinically contraindicated. All other psychopharmacologic drugs must have a reduction attempt at least in two separate quarters during the first year (with at least one month between attempts) and then annually, unless clinically contraindicated. The ultimate goal of successful GDR is to discontinue the medication, or to utilize the lowest possible dose of medication necessary for the benefit of the resident and to minimize adverse consequences."

Resident #2

Resdent #2 was admitted to the facility on 10/29/02, with diagnoses including dementia and depressive disorder.

The Minimum Data Set (MDS) dated 3/3/09, revealed the resident had moderate cognitive impairment.

Medication orders included the antidepressant medication Celexa tablet 20 mg (milligrams) once daily, with a start date of 11/21/06. The resident's care plan included the sentence, "Give Celexa tablet 20 mg Q HS; scheduled dose reduction attempts."

The record revealed a dose reduction attempt for Celexa was made on 11/06, and a second was made on 2/2/07. There was no evidence of any other GDR (gradual dose reduction)attempts for Celexa since that time.

On 6/10/09, the Director of Nursing (DON), Employee #2, confirmed there was no evidence Resident #2 received a GDR attempt for Celexa since 2/2/07. She further indicated she spoke

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with the physician on 10/23/08 regarding the GDR That conversation was documented on the evaluation notes and included the following sentences: "Per PMD (primary medical doctor). Dose reduction of Psychotropic medication is not justified for the Resident. This is related to occasional target symptoms are present."

Resident #2's behavior monitoring sheets for Celexa from the past eight-month period revealed the behaviors being monitored daily were "sad effect" and "crying." Each day had been recorded with a "0" which meant that target symptoms had not been present for eight months.

Resident #2's monthly physician reports over the past six months revealed the following sentence was found in each report: "The patient's depression is being treated Celexa 40 mg and Restoril mg for sleep. The patient feels that these medications are helping." The report did not include a clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. The DON was asked about the discrepancy in this report, as the resident was not taking Restoril, and the amount of Celexa was 20 mg. The DON acknowledged that the physician was documenting the wrong information on the reports.

On 6/11/09 at 8:00 AM the unit nurse, Employee #8, was asked if she felt that Resident #2 would know if Celexa "was helping," as the physician indicated was the case. The employee responded, "She doesn't comprehend what pills she's taking. She only understands the pain pills. She'll say, 'No, I don't want my pills' so when we give her her meds we have to say there's a pain

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pill."

Resident #10

Resident #10 was initially admitted to the facility on 1/28/04, with a readmission date of 7/27/07 and diagnoses including diabetes, hypertension, gastroesophageal reflux disease, and dementia with depression.

The MDS dated 3/3/09, revealed the resident had severe cognitive impairment.

Medication orders included the antidepressant Paxil tablet 20 mg once daily, with a start date of 7/27/07.

The resident's care plan included the sentence, "Give psychotropic medication Paxil 20 mg Q day and continue with scheduled dose reduction attempts."

Resident #10's first GDR attempt for Paxil was made on 11/11/06, the second attempt was made on 2/2/07. The DON recorded the following on 10/1/08 in the resident's evaluation notes: "Per PMD. First reduction was 11/06, second was 2/2/07. Dose reduction of psychotropic medication is not justified for the Resident. This is related to occasional target symptoms are present and psychiatric stability is incomplete. It appears that optimal dose is being administrated at this time without apparent adverse consequence. Non-pharmacological interventions have included: ruling out: heat, noise, overcrowding, pain, constipation, fever, and infection. Resident requested no further reduction. The medical director is resident's PMD."

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On 10/11/09 at 10:45 AM, the DON acknowledged that a GDR for Paxil should have been attempted on 2/2/08 and 2/2/09 per facility policy. She stated, "I should have informed the doctor to try to reduce. I missed that one." When asked if non-pharmacological interventions had been tried, she could not provide an answer. There was no evidence that the resident "requested no further reduction" for Paxil.

Resident #10's behavior monitoring sheets for Paxil for the month of May revealed the behaviors being monitored daily were "sad effect" and "crying." Each day had been recorded with a "0" meaning that target symptoms had not been present.

On 6/11/09 at 8:30 AM, Employee #8 stated, "Depressed behaviors are very rare for her (Resident #10)."

A depression review ("Geriatric Depression Scale") conducted by Social Services for Resident #10 on 12/27/07 and 3/10/09 revealed:

- On 12/27/07 it was noted, "Depression scale completed. No apparent s/sx of depression or inappropriate behavior observed at this time."
- On 3/10/09 the social worker documented, "No depression noted."

Resident #15

Resident #15 was admitted to the facility on 10/3/08, with diagnoses including dementia with depression, osteoarthrosis, and paralysis agitans.

The MDS dated 4/14/09 revealed the resident

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F 329	Continued From page 27 had modified independent cognitive impairment. Medication orders included the antimanic Lithium capsule 300 mg once daily, the antidepressant Wellbutrin tablet 150 mg twice a day, and the antidepressant Lexapro tablet 20 mg once daily. The resident's care plan did not address attempting GDRs for these three psychotropic medications. Resident #15's behavior monitoring sheets for Lithium, Wellbutrin, and Lexapro for the past six months revealed behaviors being monitored daily were, "sad effect," "crying," and "mood swings." Each day had been recorded with a "0" meaning that target symptoms had not been present for six months. On 4/14/09, Resident #15's "Geriatric Depression scale" assessment revealed the following documentation was recorded by the social worker on 4/30/09: "Pt scored 2/15 no depression noted on self report; 0/38 no depression on observations. Pt states, 'I miss my husband a lot. I like the activities.' No s/s of depression." There was no evidence in Resident #15's medical record that any GDRs were attempted since her admission date of 10/3/08. On 6/11/09, the DON acknowledged that GDRs were not attempted for the resident's three psychotropic medications.	F 329		
F 356 SS=C	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked	F 356		

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by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.

o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observation, the facility failed to post the required information on nurse staffing.

Finding include:

On 6/9/09, during the initial tour of the facility, conducted with the Director of Nursing (DON) (Employee #2) and the Administrative Assistant (Employee #3), the staffing information for nursing was not posted. Observation revealed a white board, located in a main hallway in

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F 356	Continued From page 29 proximity of the nurse's station which had sections identified for licensed nurses and the hours. The board was not dated and the sections for listing the licensed nurses, nursing assistants, and the hours were blank.	F 356		
F 364 SS=C	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that food was served at the proper temperature. Findings include: On 6/10/09 at 7:30 AM, breakfast trays were being assembled at the 300 wing satellite kitchen. A check of the food temperatures on the tray line revealed that the oatmeal was 118 degrees Fahrenheit (F), the fried eggs were 105 degrees F, and the pureed breakfast pizza was 89 degrees F. When the cook, Employee #9, was informed of the low temperatures, he quickly realized that the steam table heater had not been turned on, and he stated, "Usually it's on." He indicated that it was the dishwasher's responsibility to turn on the steam table prior to the food being delivered from the main kitchen. On 6/10/09 at 2:00 PM, during the group interview, two residents expressed their concern that hot food was served cooler than desired.	F 364		

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F 364	Continued From page 30 One resident stated, "Once in a while we get hot food." Another resident said, "It's never quite warm enough." The facility's "Meal Service" policy dated 2/05 revealed, "Cold foods will be served at 41 degrees F or lower and hot foods will be served at 140 degrees F or above. This will be determined by using appropriate food thermometer." There was no evidence that food temperatures were taken at the tray lines of the four satellite kitchens to ensure adequate temperatures were maintained.	F 364		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain sanitary conditions for the storage, preparation, and service of food. Findings include: An inspection of the facility's kitchen on 6/10/09 at 7:30 AM revealed the following:	F 371		

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The high temperature dishwashing machine, which is required to reach a temperature of 180 degrees Fahrenheit (F) during its rinse cycle, was observed to reach 147 degrees Fahrenheit (F). The next cycle reached 150 degrees F. The dietary manager, Employee #6, was informed of the discrepancy and brought in the maintenance supervisor, Employee #10. The employee stated, "They forgot to turn on the booster heater." He further indicated that it was the responsibility of the employee working in the dishwashing area to turn the heater on every morning. After Employee #10 turned on the booster heater, the rinse cycle reached the required temperature of 180 degrees. The dietary manager could not provide evidence that daily wash/rinse temperatures of the dishwashing machine were being monitored on an ongoing basis.

In the main and satellite refrigerators there were opened jugs of milk which were undated and an opened container of cottage cheese which had been dated 5/29/09. The dietary manager indicated that the kitchen's policy was to date all potentially hazardous foods upon opening, and to discard them after three days.

The wiping cloth bucket solution did not contain any sanitizer.

The environmental health specialist conducted an inspection of the kitchen on 6/9/09, and the following findings were listed on the Food Service Establishment Inspection Report:

1) Soiling of the following items: can opener, portable fan covers, oven top and door handles, spice rack and spice containers.
2) A spray bottle containing a floor cleaner was

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F 371	Continued From page 32 improperly labeled "odor eliminator." A spray bottle containing bleach water was unlabelled. 3) There were no waste receptacles at the handwashing sinks in the main kitchen. 4) Cutting boards in 3 of the 4 satellite kitchens were worn. 5) The following did not meet commercial NSF (National Sanitation Foundation) standards: a blender and crockpot in the main kitchen, toasters and microwave in the satellite kitchens. 6) Ceiling lights were in need of repair in the satellite kitchens. 7) Scoop handles were buried in the pepper and thickener containers.	F 371		
F 425 SS=B	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425		

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by:
Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to ensure appropriate measures were in place for the recapitulations of current medication orders and that there was documented clinical justification or indications to support the use of each medication for 4 of 16 residents (#8, #9, #11, #12).

Findings include:

Resident #8, #9, #11 and #12's medical records (including both hard copy chart and computerized records) failed to reveal evidence that the medications listed in the physician's order were reviewed routinely and that there was clinical justification, diagnoses or other indications to support the use of each of the medications listed on the physician's orders

The "View Prescription Order" of the computerized record lacked diagnoses or other indications to support why the medication was needed. Unless there was a specific limited number of doses or an end date, a majority of the medications specified "open ended." The review failed to provide evidence as to when the order was last reviewed by the physician.

On the morning of 6/10/09, the Director of Nursing (DON) (Employee #2) confirmed there was no documentation to support that the physician's orders which listed current medications being administered to Residents #8, #9, #11 and #12, were routinely being reviewed by the physician. The DON further confirmed that the medications listed in the physician's orders and the Medication Administration Record lacked

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F 425	Continued From page 34 justification (diagnoses) for each medication. The DON indicated that there was not a specific policy and procedure for how often the physician was to review and approve the ongoing treatment and medication regime.	F 425		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure appropriate storage of medications. Findings include: On 6/10/09 at 11:30 AM, the medication refrigerator in the medication room contained: - 2 vials of Promethazine HCL (Hydrochloride) 25 mg (milligram)/1 ml (milliliter) Lot # 313009898; Expiration date 3/09. On 6/10/09, the medication nurse removed the expired medications and placed them in the drawer for disposal.	F 431		
F 497 SS=D	483.75(e)(8) REGULAR IN-SERVICE EDUCATION The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 497		

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F 497	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on employee file review and interview, the facility failed to ensure that certified nursing assistant staff received training in the care of cognitively impaired residents. Findings include: There was no documented evidence that Employee # 6, hire date 10/7/00, received any training regarding the care of cognitively impaired residents either at the time of initial hire, or through in-service education. Although Employee #6, did not work in the Alzheimer's unit, the employee worked with cognitively impaired residents in other areas of the facility. On 6/12/09 in the morning, the administrative assistant indicated only the staff who worked in the Alzheimer's unit received a planned dementia training program. The staff who worked on the other units in the facility lacked dementia training.	F 497		